	FOR OHF USE				

LL1

2003 STATE OF ILLINOIS DEPARTMENT OF PUBLIC AID FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2003)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 LCS 4/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 004169	99		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: Heritage Manor-Springfield Address: 900 N RUTLEDGE Number	Springfield City	61938 Zip Code	I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with
	County: SANGAMON Telephone Number: (217) 789-0930 IDPA ID Number: 371359387001	Fax # ()		applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.
	Date of Initial License for Current Owners: Type of Ownership:	1996		Officer or Administrator (Type or Print Name) Craig L. Ater
	VOLUNTARY,NON-PROFIT Charitable Corp. Trust	xx PROPRIETARY Individual Partnership	GOVERNMENTAL State County	of Provider (Title) Senior V. P. & CFO (Signed)
	IRS Exemption Code	Corporation "Sub-S" Corp. xx Limited Liability Co. Trust	Other	Paid (Print Name Preparer and Title) (Date)
	In the event there are further questions about this Name: CRAIG L. ATER	Other s report, please contact: Telephone Number:)	(Firm Name & Address) (Telephone) (309)823-7135 Fax # () MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

STATE OF ILLINOIS Page 2

Facilit	ty Name & ID Numb	er Heritage Man	or-Springfield				# 0041699 Report Period Beginning: 01/01/2003 Ending: 12/31/2003
1	III. STATISTICA	L DATA					D. How many bed-hold days during this year were paid by Public Aid?
	A. Licensure/c	ertification level(s) of	care; enter number	of beds/bed days,			(Do not include bed-hold days in Section B.)
	(must agree	with license). Date of	change in licensed b	eds	9/10/03		
				_			E. List all services provided by your facility for non-patients.
	1	2		3	4		(E.g., day care, "meals on wheels", outpatient therapy)
							None
	Beds at				Licensed		
	Beginning of	Licensui	re	Beds at End of	Bed Days During		F. Does the facility maintain a daily midnight census? Yes
	Report Period	Level of C	Care	Report Period	Report Period		
	^			•	1		G. Do pages 3 & 4 include expenses for services or
1	176	Skilled (SNF	")	178	65,194	1	investments not directly related to patient care?
2		,	atric (SNF/PED)		,	2	YES NO XX
3	0	Intermediate	e (ICF)	0	0	3	<u> </u>
4		Intermediate	e/DD			4	H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
5		Sheltered Ca	are (SC)			5	YES NO xx
6		ICF/DD 16 o	or Less			6	
							I. On what date did you start providing long term care at this location?
7	176	TOTALS		178	65,194	7	Date started
	D. Conous For	41					J. Was the facility purchased or leased after January 1, 1978?
 	B. Census-For	the entire report peri		4	-		YES Date NO xx
	1	-	3 	4 1 D.: C	5		IZ W d. C. 'l'd d'C. d C. M. d' d
	Level of Care	Patient Days Public Aid	by Level of Care an	d Primary Source of	Payment	_	K. Was the facility certified for Medicare during the reporting year? YES xx NO If YES, enter number
		Recipient	Private Pay	Other	Total		YES xx NO If YES, enter number of beds certified and days of care provided 9,646
8 5	SNF	32,100	16,261	9,646	58,007	8	and days of care provided 5,040
	SNF/PED	32,100	10,201	0	36,007	9	Medicare Intermediary
	ICF			<u> </u>		10	vicular c intermediar y
	ICF/DD					11	IV. ACCOUNTING BASIS
	SC SC	0	0	0		12	MODIFIED
	DD 16 OR LESS	v	•		1	13	ACCRUAL XX CASH* CASH*
14	ΓOTALS	32,100	16,261	9,646	58,007	14	Is your fiscal year identical to your tax year? YES xx NO
	C. Damanut O.		line 14 dinided by 4.	4al Baanaad			Tax Year: Fiscal Year:
		cupancy. (Column 5, l l line 7, column 4.)	nne 14 aividea by to 88.98%	tai neenseu			* All facilities other than governmental must report on the accrual basis.
	zea aays on		33,370	=			dual go to amenda mast report on the neet an oldest

STATE	OF ILL	INOIS		
	#	0041600	Report Pariod Reginning	01/01/2003

	Facility Name & ID Number	Heritage Manor			STATE OF ILI #	LINOIS 0041699	Report Period	Beginning:	01/01/2003	Ending:	Page 3 12/31/2003	_
	V. COST CENTER EXPENSES (through	hout the report,	please round to	the nearest do	llar)						TION ONLY	
			osts Per Genera			Reclass-	Reclassified	Adjust-	Adjusted	FOR OH	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	_		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	342,843	21,588		364,431		364,431	4,594	369,025			1
2	Food Purchase		205,032		205,032		205,032		205,032			2
3	Housekeeping	165,307	36,587		201,894		201,894		201,894			3
4	Laundry	105,695	28,936		134,631		134,631		134,631			4
5	Heat and Other Utilities			163,441	163,441		163,441	2,038	165,479			5
6	Maintenance	165,620	65,068	40,907	271,595		271,595	20,448	292,043			6
7	Other (specify):*											7
8	TOTAL General Services	779,465	357,211	204,348	1,341,024		1,341,024	27,080	1,368,104			8
	B. Health Care and Programs											
9	Medical Director			17,600	17,600		17,600		17,600			9
10	Nursing and Medical Records	2,780,402	211,335	10,339	3,002,076		3,002,076		3,002,076			10
10a	Therapy	, ,	624,715	541,810	1,166,525	(815,470)	351,055	346,797	697,852			10a
11	Activities	101,123	5,672	ŕ	106,795		106,795	ŕ	106,795			11
12	Social Services	97,307		825	98,132		98,132		98,132			12
13	Nurse Aide Training	ŕ	50		50		50	3,160	3,210			13
14	Program Transportation							,	,			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,978,832	841,772	570,574	4,391,178	(815,470)	3,575,708	349,957	3,925,665			16
	C. General Administration											
17	Administrative	77,731			77,731		77,731	126,710	204,441			17
18	Directors Fees							11,492	11,492			18
19	Professional Services			369,872	369,872		369,872	(342,015)	27,857			19
20	Dues, Fees, Subscriptions & Promotions			122,059	122,059	(97,791)	24,268	(2,834)	21,434			20
21	Clerical & General Office Expenses	280,261	28,187	33,422	341,870		341,870	358,739	700,609			21
22	Employee Benefits & Payroll Taxes			744,549	744,549		744,549	51,448	795,997			22
23	Inservice Training & Education			746	746		746	1,392	2,138			23
24	Travel and Seminar			5,533	5,533		5,533	(3,534)	1,999			24
25	Other Admin. Staff Transportation				·							25
26	Insurance-Prop.Liab.Malpractice			97,779	97,779		97,779	3,546	101,325			26
27	Other (specify):*			5,223	5,223		5,223	(5,136)	87			27
28	TOTAL General Administration	357,992	28,187	1,379,183	1,765,362	(97,791)	1,667,571	199,808	1,867,379			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,116,289	1,227,170	2,154,105	7,497,564	(913,261)	6,584,303	576,845	7,161,148			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Report Period Beginning:

01/01/2003 Ending:

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V. COST CENTER EXPENSES (continued)

Facility Name & ID Number

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			297,113	297,113		297,113	17,676	314,789			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			109,159	109,159		109,159	13,581	122,740			32
33	Real Estate Taxes			111,275	111,275		111,275		111,275			33
34	Rent-Facility & Grounds							11,812	11,812			34
35	Rent-Equipment & Vehicles			910	910		910	18,217	19,127			35
36	Other (specify):*											36
37	TOTAL Ownership			518,457	518,457		518,457	61,286	579,743			37
	Ancillary Expense											4
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					815,470	815,470		815,470			39
40	Barber and Beauty Shops			16,675	16,675		16,675		16,675			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					97,791	97,791		97,791			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			16,675	16,675	913,261	929,936		929,936			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,116,289	1,227,170	2,689,237	8,032,696		8,032,696	638,131	8,670,827			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Heritage Manor-Springfield

Facility Name & ID Number Heritage Manor-Springfield

0041699 **Report Period Beginning:** 01/01/2003

Ending:

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VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	Th Column	1 2 below, reference the	1111C OII W	3	iai cos
		•	Refer-	OHF USE	
	NON-ALLOWABLE EXPENSES	Amount	ence	ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	478	35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(2,044) 32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(845) 20		17
18	Fines and Penalties				18
19	Entertainment	(13,536) 24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,793) 19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,136) 27		24
25	Fund Raising, Advertising and Promotional	(8,136	20		25
	Income Taxes and Illinois Personal				1
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29					29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (36,012)	\$	30

	OHF USE ONL	Y				
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

	2
nt	Ref

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	674,143		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 674,143		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 638,131		37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

3

4

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
	Gift and Coffee Shops					40
	Barber and Beauty Shops					41
	Laboratory and Radiology					42
	Prescription Drugs					43
	Exceptional Care Program					44
45	Other-Attach Schedule					45
	Other-Attach Schedule	_				46
47	TOTAL (C): (sum of lines 38-46)			\$		47

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Heritage Manor-Springfield

| ID# | 0041699 | Report Period Beginning: 01/01/2003 | Ending: 12/31/2003

Sch. V Line

1 S 2 3		
3		1
		2
		3
4		4
5 478	35	5
6 0	34	6
7		7
8		8
9 0	30	9
10	32	10
11		11
12		12
13 0	2	13
14	32	14
15 0	33	15
16	24	16
17 (845)	20	17
18		18
19	24	19
20 0	27	20
21		21
(6,793)	19	22
23		23
24 (5,136)	27	24
25 (8,136)	20	25
26		26
27		27
28		28
29		29
30		30
31		31
32		32
33		33
34		34
35		35
36		36
37		37
38		38
39		39
40		40
41		41
42		42
43		43
44		44
45		45
46		46
47		47
48		48
49 Total (20,432)		49

Summary A Facility Name & ID Number Heritage Manor-Springfield

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 61 01/01/2003 Ending: # 0041699 Report Period Beginning: 12/31/2003

	SUMMARY OF PAGES 5, 5A, 6, 6A	A, 6B, 6C, 6D, 6	6E, 6F, 6G, 6H	I AND 61										
													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	l
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6 I	(to Sch V, col	
1	Dietary	0	0	4,594	0	0	0	0	0	0	0	0	4,594	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0		2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	_
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	2,038	0	0	0	0	0	0	0	0	2,038	5
6	Maintenance	0	0	20,448	0	0	0	0	0	0	0	0	20,448	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	27,080	0	0	0	0	0	0	0	0	27,080	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	346,797	0	0	0	0	0	0	0	0	0	346,797	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	3,160	0	0	0	0	0	0	0	0	3,160	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	346,797	3,160	0	0	0	0	0	0	0	0	349,957	16
	C. General Administration													
17	Administrative	0	0	126,710	0	0	0	0	0	0	0	0	126,710	17
18	Directors Fees	0	0	11,492	0	0	0	0	0	0	0	0	11,492	18
19	Professional Services	(6,793)	(354,579)	19,357	0	0	0	0	0	0	0	0	(342,015)	19
20	Fees, Subscriptions & Promotions	(8,981)	0	6,147	0	0	0	0	0	0	0	0	(2,834)	20
21	Clerical & General Office Expenses	0	0	358,739	0	0	0	0	0	0	0	0	358,739	21
22	Employee Benefits & Payroll Taxes	0	0	51,448	0	0	0	0	0	0	0	0	51,448	
23	Inservice Training & Education	0	0	1,392	0	0	0	0	0	0	0	0	1,392	23
24	Travel and Seminar	(13,536)	0	10,002	0	0	0	0	0	0	0	0	(3,534)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,546	0	0	0	0	0	0	0	0	3,546	26
27	Other (specify):*	(5,136)	0	0	0	0	0	0	0	0	0	0	(5,136)	27
28	TOTAL General Administration	(34,446)	(354,579)	588,833	0	0	0	0	0	0	0	0	199,808	28
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(34,446)	(7,782)	619,073	0	0	0	0	0	0	0	0	576,845	29

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6 I	(to Sch V, col	.7)
30	Depreciation	0	0	0	17,676	0	0	0	0	0	0	0	17,676	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,044)	0	0	15,625	0	0	0	0	0	0	0	13,581	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	11,812	0	0	0	0	0	0	0	11,812	34
35	Rent-Equipment & Vehicles	478	0	0	17,739	0	0	0	0	0	0	0	18,217	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(1,566)	0	0	62,852	0	0	0	0	0	0	0	61,286	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST	_												
45	(sum of lines 29, 37 & 44)	(36,012)	(7,782)	619,073	62,852	0	0	0	0	0	0	0	638,131	45

0041699

Report Period Beginning:

01/01/2003 Ending:

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12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessa	 Enter below the names of ALI 	L owners and related organizations (parties) as defined in the instructions.	. Attach an additional schedule if necessar
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11: Einer Bolott the hamos of AEE o							
1		2		3			
OWNERS		RELATED NURSING	HOMES	OTHER RELATED BUSINESS ENTITIES			
Name	Ownership %	Name	City	Name	City	Type of Business	

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	101 determining costs as specifica i	4	. C D		_	0 Dice	
	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Sch	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					- · · · · · · · · · · · · · · · · · · ·	Ownership		Costs (7 minus 4)	
						Ownership	Organization	Costs (7 mmus 4)	
1	V			\$			\$	\$	1
2	V	10a	Adjustment for Related Organizat	tion 508,066	GreenTree Therapy	100.00%	693,973	185,907	2
3	V								3
4	V	19	Adjustment for Related Organizat	tion 354,579	Heritage Enterprises, Inc.	100.00%		(354,579)	4
5	V								5
6	V	10a	Adjustment for Related Organizat	tion 618,877	GreenTree Pharmacy	100.00%	779,767	160,890	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			s 1,481,522			s 1,473,740	§ * (7,782)	14

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

C.	$\Gamma \Lambda'$	ГF	OF	II '	LIN	IOI	C

Page 6A Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

	VII.	RELA	ATED	PARTIES	S (continued)
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B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1	mstr uct	2	or determining costs as specified for		7 C (P1 (10)) d	1 ,	_	0 D:ce	
1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
						Percent	Operating Cost	Adjustments for	
Schedule	V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V	1	Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 4,594	\$ 4,594 1	15
16	V	2	Food Purchase				0		16
17	V		Housekeeping				0		17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				2,038	2,038 1	19
20	V		Maintenance				20,448		20
21	V	7	Other				0		21
22	V		Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V		Activities				0		24
25	V		Social Service				0		25
26	V	13	Nurse Aide Training				3,160	3,160 2	26
27	V		Program Transportation				0		27
28	V		Other				0		28
29	V		Administrative				126,710		29
30	V	18	Directors Fees				11,492		30
31	V	19	Professional Services				19,357	19,357 3	31
32	V	20	Fees, Subscription, Promotions				6,147		32
33	V		Clerical & General Office Expenses				358,739		33
34	V		Employee Benefits & Payroll Taxes				51,448		34
35	V		Inservice Training & Education				1,392		35
36	V	24	Travel and Seminar				10,002		36
37	V	25	Other Admin. Staff Transportation	_			0	3	37
38	V	26	Insurance-Prop.Liab.Malpract				3,546	3,546 3	38
39 Tota	al			s			s 619,073	s * 619,073 3	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

		INOIS	

Page 6B Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

	VII.	RELA	ATED	PARTIES	S (continued)
--	------	------	------	---------	---------------

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, YES NO management fees, purchase of supplies, and so forth.

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with

the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
			-			Percent	Operating Cost	Adjustments for	
Schedu	ule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	1
					g and a second s	Ownership	Organization	Costs (7 minus 4)	
15	V	27	Other	\$	Heritage Enterprises, Inc.	100.00%			15
16	V	30	Depreciation				17,676	17,676	16
17	V	31	Amortization of Pre-Op & Org				0		17
18	V	32	Interest				15,625	15,625	18
19	V	33	Real Estate Taxes				0		19
20	V	34	Rent-Facility & Grounds				11,812	11,812	20
21	V	35	Rent-Equipment & Vehicles				17,739	17,739	21
22	V	36	Other				0		22
23	V	38	Medically Nec Transportation				0		23
24	V	39	Ancillary Service Centers				0		24
25	V	40	Barber and Beauty Shops				0		25
26	V	41	Coffee and Gift Shops				0		26
27	V	42	Other				0		27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V		_						38
39 T	otal			s			s 62,852	s * 62,852	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS Page 7 0041699 **Report Period Beginning:** 01/01/2003 12/31/2003

Ending:

VII. RELATED PARTIES (continued)

Facility Name & ID Number

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

Heritage Manor-Springfield

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6	5	7		8	
						Average Hou	rs Per Work				
					Compensation	Week Devo	oted to this	Compensatio	n Included	Schedule V.	
					Received	Facility and	% of Total	in Costs	for this	Line &	
				Ownership	From Other	Work	Week	Reporting	g Period**	Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1	Bill Froelich	Director	Management	26.00	320,135	5	100.00	Director/Salar	\$ 23,715	line 17/18, col	1
2	Tom Jefferson	Secretary	Management	10.00	385,686	5	100.00	Director/Salary	28,569	line 17/18, col	2
3	Craig Hart	Chairman	Management	20.00	372,740	10	100.00	Director/Salary	27,610	line 17/18, col	3
4	Cheryl Lowney	Executive Vice Pres	i Management	0.30	222,499	40	100.00	Director/Salary	16,481	line 17/18, col	4
5	Steve Wannemacher	President	Management	0.30	251,231	40	100.00	Director/Salary	18,610	line 17/18, col	5
6	Connie Hoselton	Sr Vice President	Management	0.20	148,865	40	100.00	Salary	11,027	line 17, col 7	6
7	Craig Ater	Sr Vice President	Management	0.20	164,565	40	100.00	Salary	12,190	line 17, col 7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 138,202		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME. ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

STATE OF ILLINOIS Page 8

Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO	City / State / Zip Code	
_	Phone Number (
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number	1

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1	1	Dietary	Beds	2,403	24	\$ 62,023	\$ 62,023	178	\$ 4,594	1
2	2	Food Purchase	Beds	2,403	24	0	0	178	0	2
3	3	Housekeeping	Beds	2,403	24	0	0	178	0	3
4	4		Beds	2,403	24	0	0	178	0	4
5	5	Heat & Other Utilities	Beds	2,403	24	27,509	0	178	2,038	5
6	6	Maintenance	Beds	2,403	24	276,052	67,064	178	20,448	6
7			Beds	2,403	24	0	0	178	0	7
8			Beds	2,403	24	0	0	178	0	8
9	10	Nursing & Medical Records	Beds	2,403	24	0	0	178	0	9
10	11		Beds	2,403	24	0	0	178	0	10
11	12	Social Service	Beds	2,403	24	0	0	178	0	11
12	13	Nurse Aide Training	Beds	2,403	24	42,658	42,572	178	3,160	12
13	14	Program Transportation	Beds	2,403	24	0	0	178	0	13
14	15		Beds	2,403	24	0	0	178	0	14
15	17	Administrative	Beds	2,403	24	1,710,580	0	178	126,710	15
16	18	Directors Fees	Beds	2,403	24	155,144	0	178	11,492	16
17			Beds	2,403	24	261,316	0	178	19,357	17
18	20		Beds	2,403	24	82,980	0	178	6,147	18
19	21	Clerical & General Office Expense		2,403	24	4,842,980	4,501,882	178	358,739	19
20		Employee Benefits & Payroll Taxe	Beds	2,403	24	694,554	0	178	51,448	20
21		8	Beds	2,403	24	18,789	0	178	1,392	21
22	24		Beds	2,403	24	135,033	0	178	10,002	22
23		Other Admin. Staff Transportatio	Beds	2,403	24	0	0	178	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	0	178	3,546	24
25	TOTALS					\$ 8,357,495	\$ 4,673,541		\$ 619,073	25

STATE OF ILLINOIS Page 8A

Facility Name & ID Number Heritage Manor-Spi	ringfield	#	0041699	Report Period Beginning:	01/01/2003	Ending:	2/31/2003
VIII. ALLOCATION OF INDIRECT COSTS							
vanished entropy of a spanner coord				Name of Relate	d Organization		
A. Are there any costs included in this report which	were derived from allocations of central	l offic	e	Street Address			
or parent organization costs? (See instructions.)	YES NO			City / State / Zij			
				Phone Number		()	
B. Show the allocation of costs below. If necessary,	please attach worksheets.			Fax Number			

	1	2	3	4	5	6	7	8	9	\Box
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1		Other	Beds	2,403		\$	\$	178		1
2	30	Depreciation	Beds	2,403	24	238,628		178	17,676	2
3	31	Amortization of Pre-Op & Org	Beds	2,403	24			178		3
4	32	Interest	Beds	2,403	24	210,931		178	15,625	4
5	33	Real Estate Taxes	Beds	2,403	24			178		5
6	34	Rent-Facility & Grounds	Beds	2,403	24	159,466		178	11,812	6
7			Beds	2,403	24	239,478		178	17,739	7
8		Other	Beds	2,403	24			178		8
9	38	Medically Nec Transportation	Beds	2,403	24			178		9
10	39	Ancillary Service Centers	Beds	2,403	24			178		10
11	40	Barber and Beauty Shops	Beds	2,403	24			178		11
12	41	Coffee and Gift Shops	Beds	2,403	24			178		12
13	42	Other	Beds	2,403	24			178		13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21	<u> </u>						-			21
22										22
23										23
24							-			24
25	TOTALS					\$ 848,503	\$		\$ 62,852	25

Facility Name & ID Number Heritage Manor-Springfield

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

_	1	2	3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amou Original	int of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related			- 1					8/	P	
	Long-Term										
1	Bank of Springfield	XX	Mortgage	\$17,720.00	05/01/02	\$ 2,800,000	\$ 2,640,888	05/1/07	variable	\$ 108,644	1
2	Bank of Springfield	XX	Mortgage Loan fees							515	2
3											3
4											4
5											5
	Working Capital										
6	Bank of Springfield	XX	Working Capital				200,000				6
7	Central Office Allocation	XX	Working Capital							15,625	7
8											8
9	TOTAL Facility Related			\$17,720.00		\$ 2,800,000	\$ 2,840,888			\$ 124,784	9
10	B. Non-Facility Related*						1	ı	ı	(0.04.0	10
10	Interest Income	.								(2,044)	
11											11
12											12
13											13
14	TOTAL Non-Facility Related					\$	\$			\$ (2,044)	14
15	TOTALS (line 9+line14)					\$ 2,800,000	\$ 2,840,888			\$ 122,740	15

16)	Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	\$ Line #	

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS Page 10
0041699 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

Facility Name & ID Number Heritage Manor-Springfield

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

D. Real Estate Taxes						Т
Real Estate Tax accrual used on 2002 report.	Important , please see the next worksheet, bill must accompany the cost report.	"RE_Tax". The real	estate tax statement and	s	112,676	1
2. Real Estate Taxes paid during the year: (Indicate the t	ax year to which this payment applies. If payment cover	rs more than one year, de	tail below.)	\$	109,244	2
3. Under or (over) accrual (line 2 minus line 1).				\$	(3,432)	3
4. Real Estate Tax accrual used for 2003 report. (Detail	and explain your calculation of this accrual on the lines	below.)		s	114,707	4
5. Direct costs of an appeal of tax assessments which has (Describe appeal cost below. Attach copie	NOT been included in professional fees or other gener s of invoices to support the cost and a cop			s		5
6. Subtract a refund of real estate taxes. You must offset classified as a real estate tax cost plus one-half of any TOTAL REFUND \$ For	2 11	al estate tax appeal	board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line	33. This should be a combination of lines 3 thru 6.			\$	111,275	7
Real Estate Tax History:						
Real Estate Tax Bill for Calendar Year: 1998	8		FOR OHF USE ONLY			
1999 2000	9 10	13	FROM R. E. TAX STATEMENT FOR	R 2002 \$		13
2001 2002	11 12	14	PLUS APPEAL COST FROM LINE	5 \$		14
		15	LESS REFUND FROM LINE 6	s		15
		16	AMOUNT TO USE FOR RATE CAL	CULATION \$		10

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- If facility is a non-profit which pays real estate taxes, you must attach a denial of an
 application for real estate tax exemption unless the building is rented from a for-profit entity.
 This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

FACILITY NAME Heritage Manor-Springfield

is normally paid during 2003.

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

COUNTY SANGAMON

FACILITY ID	PH LICENSE NUMBER	0041699				
CONTACT PE	ERSON REGARDING THI	S REPORT				
TELEPHONE	()	FAX	#: ()			
A. Summai	ry of Real Estate Tax Cos					
cost that home pro	applies to the operation of operty which is vacant, rent	estate tax assessed for 2002 on the nursing home in Column D. ed to other organizations, or use de cost for any period other than	Real estate ta d for purpose	x applicable to ar s other than long	ny portion o	f the nursing
	(A)	(B)		(C)		(D) <u>Tax</u> Applicable to
Ta	x Index Number	Property Description		Total Tax	<u>N</u>	ursing Home
1. 1428027	7027	Heritage Manor-Springfield	\$	109,245.00	\$	109,245.00
2.			\$		\$	
3.			\$		\$	
4.			\$		\$	
5.			\$			
6.			\$		\$	
7.			\$		\$	
8.			\$		\$	
9.			\$		\$	
10.					\$	
		TOTA	LS \$	109,245.00	\$ _	109,245.00
B. Real Est	tate Tax Cost Allocations					
	y portion of the tax bill app nursing home services?	ly to more than one nursing hom YES	e, vacant prop NO	perty, or property	which is no	t directly
		chedule which shows the calcula ust be allocated to the nursing h				me.
C. Tax Bill:	<u>s</u>					

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which

Page 10A

STATE OF ILLINOIS Page 11 Facility Name & ID Number Heritage Manor-Springfield # 0041699 Report Period Beginning: 01/01/2003 Ending: 12/31/2003 X. BUILDING AND GENERAL INFORMATION: **B.** General Construction Type: **Number of Stories** Square Feet: Exterior (c) Rent from Completely Unrelated Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. Organization. (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.) (c) Rent equipment from Completely Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. Unrelated Organization. (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.) List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable). YES NO Does this cost report reflect any organization or pre-operating costs which are being amortized? If so, please complete the following: 1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized: 3. Current Period Amortization: 4. Dates Incurred: Nature of Costs: (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 630,000	1
2					2
3	TOTALS			\$ 630,000	3

0041699

Report Period Beginning:

01/01/2003 Ending:

Page 12 12/31/2003

Facility Name & ID Number Heritage Manor-Springfield # 0041

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	ing Depreciation-Including Fixed Equ	2	3	4	5	6	7	8	9	T
		FOR OHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	178		1963		\$ 1,870,000	\$		\$	\$	\$	4
5			1966		1,648,258						5
6			1999								6
7											7
8											8
		ovement Type**	•								
	1985 Improve			1985	26,076						9
	1986 Improve			1986	216,545						10
	1987 Improve			1987	593,121						11
	1988 Improve			1988	29,321						12
	1989 Improve			1989	1,095						13
	1990 Improve			1990	939						14
	1991 Improve			1991	32,022						15
	1992 Improve			1992	32,593						16
17	1993 Improve	ements		1993	105,986						17
	1994 Improve			1994	59,542						18
	1995 Improve			1995	36,126						19
	Laundry Chu	te		1996	4,926						20
	Door Alarm			1996	8,533						21
	Garbage Disp	oosal		1996	1,113						22
	Elevator			1996	11,439						23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31 32											31
33											32
	C/O Allegation							17.677	17,676		33
	C/O Allocatio					210,975		17,676 210,975	17,676	1,893,164	34 35
	Book Depreci	auon				210,975		210,975		1,893,104	
36											36

See Page 12A, Line 70 for total

^{*}Total beds on this schedule must agree with page 2.
**Improvement type must be detailed in order for the cost report to be considered complete.

	B. Building Depreciation-Including Fixed Equipment. (See instr	uctions.) Round	all numbers to near						
	1	. 3	4	5	6	7	8	9	
		Year		Current Book	Life	Straight Line		Accumulated	
	Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37	Vent Shaft		s 6,267	\$		\$	\$	\$	37
38	Fire Dampers	1997	510						38
39	Computer Cabling	1997	14,518						39
40	Rehab Therapy Room	1997	7,391						40
41	Air ConditionerChiller	1997	47,954						41
42	Remodel First Floor	1997	27,570						42
43									43
44	Landscape	1998	2,410						44
45	Vent Work	1998	7,018						45
46	Asphalt Ramp	1998	850						46
47	Room Remodel	1998	1,142						47
48									48
49	Code Alert	1999	7,829						49
50	Wall Paper	1999	704						50
51	Remodel Office Interior	1999	1,248						51
52	Elevator Repair	1999	2,697						52
53	Carpet	1999	1,097						53
54									54
55	Shed Yardmate	2000	522						55
56	A/C Rooftop Unit	2000	2,937						56
57	Sewerline Repair	2000	1,482						57
58									58
59	Facility RenovationMaterials	2001	745,911						59
60	Facility RenovationLabor	2001	1,463						60
61	Facility RenovationInterior Design	2001	69,313						61
62	Fire Alarm System	2001	8,718						62
63	Sewer Line Repair	2001	1,787						63
64									64
65	Facility renovations: Paint, wallpaper, fixtures, floor coverings for	r all resident							65
66	rooms including hallways and common areas								66
67	•								67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 5,638,973	\$ 210,975		\$ 228,651	\$ 17,676	\$ 1,893,164	70

 $^{{\}rm **Improvement\ type\ must\ be\ detailed\ in\ order\ for\ the\ cost\ report\ to\ be\ considered\ complete}.$

0041699 Report Period Beginning:

g: 01/01/2003 Ending: Page 12B 12/31/2003

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar. Year **Current Book** Life Straight Line Accumulated Improvement Type** Constructed Depreciation Depreciation Depreciation Cost in Years Adjustments 17,676 1 Totals from Page 12A, Carried Forward 5,638,973 210,975 228,651 1,893,164 1 2 Landscape Design 2 3 Freezer Compressor 2002 3,834 3 2002 2,560 4 4 Smoke Detectors 2002 5 5 Facility Renovation--Materials 186,172 6 Facility Renovation-Labor 3,561 15,497 7 7 Facility Renovation--Interior Design 2002 8 8 Phone System 2,064 9 10 Door Security 2003 2,597 10 11 Generator 2003 20,145 11 2003 2003 2003 2003 2003 2003 1,216 9,244 12,378 12 Door Replacement 12 13 13 Generator Replacement 14 Elevator Repair 14 17,153 15 15 Shower Room Remodel 16 Hallway carpet 16 17 3,889 17 Boiler Door 2003 854 18 18 19 19 20 21 20 21 22 22 23 24 25 23 24 25 26 26 27 27 28 29 28 29 30 30 31 31 32 32 33 34 TOTAL (lines 1 thru 33) 5,920,637 210,975 228,651 17,676 1,893,164 34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

STA	TE	OF	HI	INOL	ς

Page 13 12/31/2003 Facility Name & ID Number Heritage Manor-Springfield 0041699 **Report Period Beginning:** 01/01/2003 Ending:

XI. OWNERSHIP COSTS (continued)

C. 1	Equipment	Depreciation-	Excluding Trans	sportation. (Sec	e instructions.)

	Category of	l 1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 1,192,171	\$ 86,138	\$ 86,138	\$		\$ 991,846	71
72	Current Year Purchases	19,044						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 1,211,215	\$ 86,138	\$ 86,138	\$		\$ 991,846	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

	E. Summary of Care-Related Assets	I		2		
		Reference		Amount]
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	7,761,852	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	297,113	82	1
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	314,789	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	17,676	84	
85	Accumulated Depreciation	(line 70, col 9 + line 75, col 6 + line 80, col 9) + (Pages 12R thru 12L if applicable)	9	2 885 010	85	1

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

Page 14

XII. RENTAL COSTS A. Building and Fixed Equipment (See instructions.) 1. Name of Party Holding Lease: 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. YES NO	12/31/2003
Year Constructed of Beds Lease Amount Original 3 Building: 4 Additions 5 S S S S S S S S S S S S S S S S S S S	
Constructed of Beds Lease Amount of Lease Renewal Option* Original Building: Additions Additions Beginning Ending Ending TOTAL S ** 8. List separately any amortization of lease expense included on page 4, line 34. ** ** ** ** ** ** ** ** **	
Original 3 Building: 4 Additions 5	
3 Building: \$ 3 Beginning Ending 4 Additions 4 4 Ending Ending 5	ment•
4 Additions	ment.
6	
7 TOTAL S ** 7 rental agreement: 8. List separately any amortization of lease expense included on page 4, line 34. Fiscal Year Ending Annual I	
8. List separately any amortization of lease expense included on page 4, line 34. Fiscal Year Ending Annual I	the current
This amount was calculated by dividing the total amount to be amortized by the length of the lease 9. Option to Buy: B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.) 15. Is Movable equipment rental included in building rental? YES NO 12. 2004 \$	lent
16. Rental Amount for movable equipment: \$ 19,127 Description: pager, computer equipment (Attach a schedule detailing the breakdown of movable equipment)	
C. Vehicle Rental (See instructions.)	
C. venter Kental (See instructions.)	
Model Year Monthly Lease Rental Expense	
Use and Make Payment for this Period * If there is an option to buy the buil	
17 S \$ 17 please provide complete details on a	ttached
18 18 schedule. 19 19	
20 ** This amount plus any amortization	of lease
21 TOTAL \$ \$ 21 expense must agree with page 4, lin	

		STATE OF ILLIN	OIS			Page 15
Facility Name & ID Number	Heritage Manor-Springfield		# 0041699	Report Period Beginning:	01/01/2003 Ending:	12/31/2003
XIII. EXPENSES RELATING TO NUI	RSE AIDE TRAINING PROGRAMS (Se	e instructions.)				
A. TYPE OF TRAINING PROGE	AM (If aides are trained in another facil	ity program, attach a schedule listing th	e facility name, addre	ss and cost per aide trained in t	hat facility.)	
1. HAVE YOU TRAINED A		2. CLASSROOM PORTION:	_	3. CLINICAL PO	ORTION:	
DURING THIS REPORT PERIOD?	NO NO	IN-HOUSE PROGRAM		IN-HOUSE PR	ROGRAM	
If "yes", please complete	the remainder	IN OTHER FACILITY		IN OTHER FA	ACILITY	
of this schedule. If "no", explanation as to why thi	provide an	COMMUNITY COLLEGE		HOURS PER	AIDE	
not necessary.	straining was	HOURS PER AIDE				
B. EXPENSES	ALLOC	ATION OF COSTS (d)		C. CONTRACTUAL I	NCOME	
	MELOCI	(u)		In the hey hele	w record the amount of in	oomo vour

Contract

Facility

Completed

50

Drop-outs

50

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(a)

(b)

(c)

(e)

1 Community College Tuition

5 In-House Trainer Wages

SUM OF line 9, col. 1 and 2

2 Books and Supplies

3 Classroom Wages

4 Clinical Wages

6 Transportation
7 Contractual Payments
8 Nurse Aide Competency Tests

TOTALS

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

In the box below record the amount of income your facility received training aides from other facilities.

\$	

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

Total

50

50

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Page 16

12/31/2003

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

Facility Name & ID Number

	(STEELE SERVICES (SHOOT COST)	1	2	3	4	5	6	7	8	
		Schedule V	Staf	f	Outsid	e Practitioner	Supplies			
	Service	Line & Column	Units of	Cost	(other t	han consultant)	(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist		hrs	\$		\$ 257,536	\$		\$ 257,536	1
	Licensed Speech and Language									
2	Development Therapist		hrs			38,751			38,751	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			397,685	3,879		401,564	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts				781,726		781,726	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					33,744			33,744	13
14	TOTAL			\$		\$ 727,716	\$ 785,605		\$ 1,513,321	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Buildings, at Historical Cost

Equipment, at Historical Cost

Accumulated Amortization -

TOTAL Long-Term Assets

(sum of lines 11 thru 23)

Deferred Charges

Restricted Funds

Other(specify):

TOTAL ASSETS
25 (sum of lines 10 and 24)

22

23

Leasehold Improvements, at Historical Cost

Accumulated Depreciation (book methods)

Organization & Pre-Operating Costs

Organization & Pre-Operating Costs

Other Long-Term Assets (specify):

	This report must be completed even if financial statements are attached.					
		1 0	perating	2 After Consolidation*		
	A. Current Assets					
1	Cash on Hand and in Banks	\$	288,378	\$	1	
2	Cash-Patient Deposits		17,207		2	
	Accounts & Short-Term Notes Receivable-					
3	Patients (less allowance)		866,806		3	
4	Supply Inventory (priced at)				4	
5	Short-Term Investments				5	
6	Prepaid Insurance		40,414		6	
7	Other Prepaid Expenses				7	
8	Accounts Receivable (owners or related parties)		15,971		8	
9	Other(specify):				9	
	TOTAL Current Assets					
10	(sum of lines 1 thru 9)	\$	1,228,776	\$	10	
	B. Long-Term Assets					
11	Long-Term Notes Receivable				11	
12	Long-Term Investments				12	
13	Land		630,000		13	

5,950,638

1,211,215

(2,885,010)

1,640,341

6,547,184

7,775,960

		1	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	215,001	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		17,207		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable				30
	Accrued Taxes Payable				
31	(excluding real estate taxes)				31
32	Accrued Real Estate Taxes(Sch.IX-B)		114,707		32
33	Accrued Interest Payable		8,411		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Escrow				36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	355,326	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable		2,840,888		40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	2,840,888	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	3,196,214	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	4,579,746	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	/ \$	7,775,960	\$	48
	/				

01/01/2003

Ending:

Page 17 12/31/2003

14

15

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17

18

19

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21

22

23

24

25

^{*(}See instructions.)

Facility Name & ID Number Heritage Manor-Springfield XVI, STATEMENT OF CHANGES IN EQUITY

0041699

Report Period Beginning: 01/01/2003

Ending:	12/31

		1	
		Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,680,885	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,680,885	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,139)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(100,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (101,139)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,579,746	24

^{*} This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 8,005,805	1
2	Discounts and Allowances for all Levels	(2,355,172)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,650,633	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,281,660	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 1,281,660	8
	C. Other Operating Revenue		
9	Payments for Education		9
	Other Government Grants		10
	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	3,080	12
13	Barber and Beauty Care	24,405	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,069,635	17
18	Sale of Supplies to Non-Patients		18
	Laboratory		19
	Radiology and X-Ray		20
21	Other Medical Services	100	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 1,097,220	23
	D. Non-Operating Revenue		
24	Contributions		24
	Interest and Other Investment Income***	2,044	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 2,044	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 8,031,557	30

			2	
	Expenses		Amount	
	A. Operating Expenses			
31	General Services		1,341,024	31
32	Health Care		4,391,178	32
33	General Administration		1,765,362	33
	B. Capital Expense			
34	Ownership		518,457	34
	C. Ancillary Expense			
35	Special Cost Centers		16,675	35
36	Provider Participation Fee			36
	D. Other Expenses (specify):			
37				37
38				38
39				39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	8,032,696	40
41	Income before Income Taxes (line 30 minus line 40)**		(1,139)	41
42	Income Taxes			42
12	NET INCOME OF LOSS FOR THE VEAR (\$\frac{1}{2} \cdot 41 \cdot \frac{1}{2} \cdot \cdot 42)	6	(1.120)	12
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	(1,139)	43

*	This must	t agree with	page 4,	line 45,	column 4.
---	-----------	--------------	---------	----------	-----------

*	Does this agree with	taxable income (loss) per Federal Income
	Tax Return?	If not, please attach a reconciliation.

^{***} See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Springfield

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,992	2,080	\$ 54,228	\$ 26.07	1
2	Assistant Director of Nursing	1,922	2,430	49,560	20.40	2
3	Registered Nurses	27,483	28,936	623,597	21.55	3
4	Licensed Practical Nurses	48,089	51,706	826,252	15.98	4
5	Nurse Aides & Orderlies	101,557	108,331	1,211,250	11.18	5
6	Nurse Aide Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,477	1,679	15,515	9.24	8
9	Activity Director					9
10	Activity Assistants	10,361	11,092	101,123	9.12	10
11	Social Service Workers	5,607	6,302	97,307	15.44	11
	Dietician					12
	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	36,597	39,377	342,843	8.71	15
16	Dishwashers					16
17	Maintenance Workers	16,224	17,311	165,620	9.57	17
	Housekeepers	17,487	18,473	165,307	8.95	18
19	Laundry	10,510	11,123	105,695	9.50	19
20	Administrator	2,080	2,080	77,731	37.37	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
	Clerical	17,976	20,209	280,261	13.87	24
	Vocational Instruction					25
26	Academic Instruction					26
	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	299,362	321,129	s 4,116,289 *	\$ 12.82	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		s 0		35
36	Medical Director		17,600		36
37	Medical Records Consultant		0		37
38	Nurse Consultant				38
39	Pharmacist Consultant		4,134		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		825		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		s 22,559		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses		\$ 0		50
51	Licensed Practical Nurses		0		51
52	Nurse Aides		0		52
53	TOTAL (lines 50 - 52)		\$		53
	•			-	

^{**} See instructions.

	STATE C)F ILLI	NOIS
#	0041699		

					STATE OF ILLINOIS					e 21
	Heritage Manor-Sprin	gfield			#_ 0041699	Rep	ort Period Beg	inning: 01/01/2003	Ending:	12/31/2003
XIX. SUPPORT SCHEDULES		Ownershi			D F			F. Dues, Fees, Subscriptions and P	·	
A. Administrative Salaries Name	Function	Ownersh %	ıp	Amount	D. Employee Benefits and Payroll Taxes Description		Amount	Description	romotions	Amount
Ruth Kopec		0	\$	77,731	Workers' Compensation Insurance	s	67,634	IDPH License Fee	s	Amount
Ruth Kopec	Admin			77,731	Unemployment Compensation Insurance	_ •	27,172	Advertising: Employee Recruitment		2,50
					FICA Taxes		314,896	Health Care Worker Background		2,50
					Employee Health Insurance		300,426	(Indicate # of checks performed	CHeck	55
_		-			Employee Meals		300,420	Central Office Allocation	<u> </u>	6,14
					Illinois Municipal Retirement Fund (IMRF)			Promotional Advertising		6,53
					1 ,		4.050	Public Relations		
FOTAL (C.L. L. V. L.	171.1\				Employee Hepatitis Vaccine		4,059			1,59
TOTAL (agree to Schedule V, line			e	77.721	Employee Benefits - Employee Benefits - central office		30,362 51,448	Dues and Subscriptions License and Fees		12,474 603
List each licensed administrator	separately.)		<u> </u>	77,731	Employee Benefits - central office		51,446	License and Fees		00
B. Administrative - Other								Less: Public Relations Expense	 .	(1,59
Description				Amount				Non-allowable advertising	·	(84
Description		•	Amount				Ü			
			_ >_					Yellow page advertising		(6,53)
					TOTAL (agree to Schedule V,	e.	795,997	TOTAL (agree to Sch.	v c	21.43
					,	Ф.	193,991	, 0	۷, ه	21,43
TOTAL (agree to Schedule V, line	a 17 apl 2)				line 22, col.8) E. Schedule of Non-Cash Compensation Paid			line 20, col. 8) G. Schedule of Travel and Semina	**	
, ,			3 =		-	a		G. Schedule of Travel and Semina	I	
(Attach a copy of any managemen C. Professional Services	it service agreement)				to Owners or Employees			D t t		
	TED.				.			Description		Amount
Vendor/Payee	Type			Amount	Description Line #		Amount	0 . 40		
Heritage Enterprises	Management Fees		_ \$_	354,579		\$		Out-of-State Travel		
Sulaski & Webb	Audit			8,500						
				0						
								In-State Travel		
										2,72
								Seminar Expense		2,80
								Non Allowable		(13,53
				0				Central Office Allocation		10,00
Legal Fees (Adjusted to zero)				6,793						
				0				Entertainment Expense	(
ГОТАL (agree to Schedule V, line	,				TOTAL	\$		(agree to Sch. V,		
(If total legal fees exceed \$2500 at	tach copy of invoices.)		\$	369,872				TOTAL line 24, col. 8)	\$	1,999

* Attach copy of IMRF notifications

**See instructions.

Report Period Beginning: 01/01/2003

Ending:

Page 22 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
	_	Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful	EX.2000	EX.2004	EX.2002	EX /2002	EX /2004	EX.200#	ENGOGG	EX.200#	EX.2000
	Туре	Was Made		Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16	·												
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility	S y Name & ID Number Heritage Manor-Springfield		OF ILLINOIS # 0041699	Report Period Beginning:	01/01/2003	Ending:	Page 23 12/31/2003
XX. G	ENERAL INFORMATION:						
	Are nursing employees (RN,LPN,NA) represented by a union? No	(13)		applies and services which are of the Public Aid, in addition to the daily			
(2)	Are there any dues to nursing home associations included on the cost report? Yes If YES, give association name and amount. Illinois Healthcare Association		in the Ancillary Sec	etion of Schedule V? Yes	_		
(3)	Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes	(14)	the patient census li is a portion of the b	uilding used for any function other isted on page 2, Section B? No uilding used for rental, a pharmacy eplains how all related costs were a	, day care, etc.)	For example If YES, attac	le,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?	(15)	Indicate the cost of on Schedule V. related costs?		assified to employ meal income be the amount. \$	een offset ag	ainst
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? Yes 7 Years	(16)	Travel and Transpo	rtation acluded for out-of-state travel?	No		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10		If YES, attach a cb. Do you have a se residents?	complete explanation. parate contract with the Department of YES, please indicate the	nt to provide me		
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.		c. What percent of a	his reporting period. \$ all travel expense relates to transpoge logs been maintained? Yes	rtation of nurses	and patients	? 100
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.		e. Are all vehicles s times when not in	tored at the nursing home during the	_		
(9)	Are you presently operating under a sublease agreement? YES xx NO)	out of the cost re		· ·		
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO No If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over.	,,	Indicate the ar	nount of income earned from during this reporting period.	providing sucl	h	
		(17)	Firm Name: Pel	erformed by an independent certification of the liman & Dold	•	The instruct	tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 97,791 This amount is to be recorded on line 42 of Schedule V.		been attached?	hat a copy of this audit be included If no, please explain.	Not Comple	te as of this o	date
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.		out of Schedule V?			-	
		(19)	performed been atta	e in excess of \$2500, have legal in ached to this cost report? I a summary of services for all arch		-	rices

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